Medical Societies

MONTREAL MEDICO-CHIRURGICAL SOCIETY

THE eleventh regular meeting of the society was held March 1st, 1918, Dr. A. E. Garrow, president, in the chair.

PATHOLOGICAL SPECIMENS: Series by Dr. Horst Oertel.

1. This specimen is a very extensive case of fat necrosis of the pancreas. It will be seen that practically a complete sequestration of the pancreas has occurred and there is nothing left of it except tinder-like shreds of tissue which occupy the omental bursa; in other words the fat necrosis has become so extensive as to involve and destroy the whole of the pancreas. But it has extended further into the surrounding omental and mesenteric fat tissue and a great deal of this has completely liquified so that at autopsy it formed an almost purulent looking mass. Such an extensive condition is uncommon, although not unknown. The case occurred in Dr. Keenan's service at the Royal Victoria Hospital, who had already made the clinical diagnosis of fat necrosis of the pancreas on the admission of the patient. It is interesting that in this, as in most of these cases, there also existed gall stones, but we have been unable to find any obstruction of either the bile ducts or the duct of Santorini. If you turn up the stomach and reflect it in this specimen you will see well the empty omental bursa but for the shreddy remains of pancreatic tissue.

2. The second specimen is one which represents an interesting lesion in an infant which died almost immediately after birth, having hardly breathed. It came to use from the Maternity Hospital. Here is the whole of the thorax into which two windows have been cut and it will be seen that on the left side there is a large diaphragmatic hernia through which have passed many loops of gut and also the greater part of the left lobe of the liver. There has been an almost complete twisting of the heart to the right side so that the vessels of the heart are displaced and kinked. Very little is to be seen of the left lung which is just visible in the upper part of the thorax. The hernial opening is covered by a loose, fine,

fibrous membrane which may be peritoneum, but is more likely a loose tendinous portion of the diaphragm. The gut and liver were covered by this membrane in the pleural cavity. There can be little doubt that the lesion is a developmental one. It is unusually large.

The anatomical findings demonstrate that life could not be compatible with these circumstances and the child therefore died as soon as it was severed from the nutritive connection with the mother:

Discussion. Dr. A. D. Blackader: I would like to ask if the sudden death was due to the condition of the heart, because a good many cases are reported of diaphragmatic hernia into the lungs having existed for some time, and was it the condition of the heart in this case which gave rise to this sudden death.

Dr. Maude E. Abbott: Was there any defect in the pericardium?

Dr. H. Oertel: As far as Dr. Blackader's question is concerned it is true that diaphragmatic hernias are by no means very infrequent. They result from lack of proper separation of the pleural cavity from the abdominal cavity. Many are compatible with life and even unrecognized until autopsy, as we also find it at times in peritoneal-pericardial hernia. Some years ago I autopsied a man well over middle age in which several loops of intestine were found in the pericardium. In this case, however, several conditions would appear to make it impossible for life to go on, the diaphragmatic hernia was so very large and complete that not only a great part of gut but a good portion of the liver passed into the pleural cavity. By this means aeration of the lung was made impossible and the lung remained really as a fœtal gland in the upper thorax. There is a similar lack of lung expansion on the right side as heart and blood vessels were moved over and in addition kinking of the large heart blood vessels must have been a tremendous impediment to circulation. As far as the pericardium is concerned it is quite intact, well formed, completely separated from the pleura and from the diaphragm. Whether there is a malformation of the heart itself we have not as yet determined, as the specimen is still intact.

Papers: "Polya's Operation in Gastrectomy for Garcinoma. With report of three cases," by Dr. E. M. von Eberts. (Published in this issue.)

Discussion: Dr. A. E. Garrow: The original operation, as proposed by Polya, has many technical difficulties in the perform-

ance of it. Dr. von Eberts made the statement that one great advantage was that it could be done as a one-stage operation. I think personally that that is its weakest point, because we are called upon to operate on these cases often when their condition is very poor; the patient has been starving for weeks, probably for months. The growth on examination may be not very large and quite removable but the patient's condition is such that they cannot withstand a partial gastrectomy. These cases can be tided over by a rapid gastroenterostomy, or a posterior operation which does not limit a subsequent gastrectomy. That is one of the criticisms I have to make, that it interferes with the simple problem of providing drainage for the stomach and giving the patient an opportuntiy to feed up for two or three weeks. The second objection is a technical difficulty. In performing the operation for cancer, particularly where he follows the so-called Hartman lines, to draw this section of the stomach through the transverse mesocolon and to stitch this for at least three quarters of an inch outside this incision is a very difficult matter. I have tried it several times after having cut the stomach to see if I could do it and I could not bring the transverse mesocolon up to that point. Where the stomach is very markedly dilated that can be done. To overcome this difficulty some have recommended another modification, that is, partially close half or a third of the section and then to do an anastomosis with the lower part. You have the same difficulties and the same dangers to contend with that Bilroth had in his anastomosis of the duodenum. The modification referred to as having been carried out in the Mayo Clinic has a good many difficulties, particularly doing the anterior gastroenterostomy and does not present any of those more serious difficulties to my mind which the original Polya operation had. One trouble that seemed to me rather difficult to overcome was that after dissection of the stomach, as recommended by Polya or the Mayo's modification, to put on a second clamp. After having sectioned the stomach by means of the cautery and taken off your Polya's clamp and then to put a second clamp in behind in order to get the anastomosis, that is rather difficult, particularly in the case in which Dr. von Eberts performed it where he had made the section transverse and very high; it must have been difficult to get the stump of the operation closed. It seems to be the ideal operation nevertheless by that third method, bringing the jejunum over the transverse colon and in through the transverse mesocolon and simply performing an antero-gastroenterostomy.

In connection with this subject I want to show a very extensive cancer of the pyloric antrum which has several very interesting features: The patient was a young man aged twenty-five, and had no symptoms other than vomiting, loss of weight and strength. He had applied to the Aviation Corps and had been accepted last October and the history only goes back three months. In performing the operation I made a resection through the lines of the œsophagus vertically downwards and instead of attempting the Polya operation made an antero-gastroenterostomy in this position. The objection to that, as pointed out by Dr. von Eberts, does not hold so much in the anterior as in the posterior, the danger of cutting off the blood supply and having necrosis or leaking of your anastomosis of leaking of your line of section. I think, however, that with improved technique, that Polya's operation in partial gastrectomy will in suitable cases where the patient's condition is such that the complete operation can be done in one stage, will be the operation of choice, it has so many features to recommend it and particularly that in neither of these three cases had Dr. von Eberts any post operative vomiting and in an extensive resection such as he carried out it is one of the most important things that you are able to begin to feed your patient early.

Dr. E. M. von Eberts: With regard to the question of deciding whether it should be a one or a two-stage operation, the two-stage operation should be performed only when absolutely necessary. If improvement is marked after the first stage a second operation may be declined; and again, in the two-stage operation one may have to deal with extensive adhesions which may complicate the technique of the second operation seriously.

2. A Short Note on Irregularities of the Heart in Association with Visceroptosis, by Dr. W. S. Morrow. (Published in this issue.)

Discussion: Dr. W. F. Hamilton: It would appear that cardioptosis is not an uncommon condition in connection with ptosis of other organs. *X*-ray examinations have proved this clearly and if one attends a clinic for a few years one would find scores of cases of "hanging heart", especially with long chest, low diaphragm, low kidney, and low stomach. Just what relation cardioptosis bears to neurasthenia is very difficult to define. I am inclined to think that the ptosis of the heart is but a small factor in the whole case and that the irregularity and disturbed cardiac function is a result rather of a general condition than of any local alteration of position the heart may show. It is true that the

possibility exists but I regard these cases in the light of a general condition rather than otherwise. One is reminded of cases of altered cardiac function where a very definite abdominal condition exists, e.g. gall stones. It is well known that recurrent gall stone attacks are associated with marked changes of cardiac function and on removal of the gall stones the heart returns to its normal state. Those cases of neurasthenia with panting in climbing up a hill should be regarded as possessing organic change, and not as cardiac neurasthenia. The musculature of these cases is impaired by toxins from nephritis or other causes.

Dr. W. S. Morrow: In reply to Dr. Hamilton I would say that I am quite ready to admit much of what he has said in a general way. At the beginning of my paper I spoke of how we all recognize a possible relation between general neurasthenia and cisceroptosis, but the point that I wanted to draw attention to was that in some cases we find disturbed heart action with very slight symptoms of neurasthenia in which the readiness with which the heart becomes affected on slight exertion is almost the only thing to suggest the possible presence of visceroptosis. As to the heart muscle being always diseased in these cases I must say that I cannot altogether accept this view because some of them seem to improve very much on fairly simple treatment. I have seen a great many cases in the last few years and my own impression is that when they are a good deal in the erect position there is liable to be a certain amoung of dragging on the abdominal organs which produces a condition of fatigue or irritation that makes them very liable to this irregular heart action. Certainly a good many of these show considerable dilatation but in many the heart seems to act normally at times and the symptoms assume the form of attacks of paroxysmal tachycardia which usually recover very quickly, so much so that if I find the heart is down two or three spaces I am apt to give a more favourable prognosis in a case of tachycardia than if I cannot find cardioptosis present as a possible cause. I think Dr. Hamilton may go a little to the extreme in minimising the possible eflect of the ptosis itself, but I am quite willing to admit that there may often be more or less organic change associated with it.

Living Case: Intussusception in a Young Child with Torsion of the Small Intestine, by Dr. A. E. Garrow.

The child is six months of age and came into hospital about twenty-four hours after being seized with an attack of abdominal

pain with vomiting, the child was admitted about four o'clock in the afternoon having taken ill the night before. It is a breast fed baby, always in perfect health until the evening of February 6th. I saw the child on the afternoon of the following day with a history that it had passed a very restless night. After having this attack of abdominal pain and vomiting it passed blood or bloody stools on several occasions; vomiting was not very frequent. There was no distension of the abdomen but a definite sausage-shaped mass, best felt from the splenic flexure downwards along the descending colon as far as the brim of the pelvis. It had a characteristic feel, was sausage-shaped, curbed, and hardened during examination, but became soft at times. When it hardened the child was restless, though it did not cry very much, indeed was very quiet. The child was rather pale and on rectal examination a little bloody mucus escaped. Operation was performed soon after it entered the hospital and the interesting feature was that on opening the abdomen a markedly distended small intestine and markedly contracted small intestine. This was found to be due to torsion of the small bowel in its upper portion, apparently in the jejunum, the torsion being to the left and one and a half complete turns was required before the kink was taken out of the small intestine. This apparently had not long existed because there was not very much alteration in the colour of the bowel; whether it had been a more recent addition to the intussusception I cannot say. This had advanced as far as the left iliac fossa and was exceedingly easily reduced. In fact all that was necessary was to lift up the sigmoid bit by bit and it receded. It was the small intestine which had invaginated. Just when the intussusception was reduced the child stopped breathing and became of a leaden hue and the condition was alarming. While Dr. Bourne was giving the anæsthetic we carried out artificial respiration with cardiac massage and improvement occurred in a minute or two. The incision which I employed here is an incision through the rectus muscles displacing the rectus outward so that no nerve supply is cut. The advantage of this is seen; there is no weakness in the child's abdomen and healing was by primary intention and no attempt was made, nor have I ever made any attempt in reducing these, to do any stitching or shortening of the mesentery. I have had no recurrences and I have not practised any of the methods which have been recommended for preventing recurrences. I could not account for the alarming symptoms which developed at the time the intussusception was reduced; I did it without any dragging, simply lifting the

sheath and following it down and the intussusception reduced itself without the slightest difficulty.

Dr. Winnifred Cullis, Professor of Physiology in the London School of Medicine for Women, London, England, and a member of the British Commission on Venereal Disease, gave a graphic and very interesting account of the educational side of the campaign now being conducted against the social evil in Great Britain and Ireland. Her address was received with the closest attention, and was followed by a discussion in which the need of the development of the campaign along similar lines in this city and province was emphasized, and the active support by the profession of measures tending to this end, urged.